Bayou Health Provider Call – Summary
January 21, 2015

FOLLOW-UP ASSIGNMENTS	See follow up in Q&A below
1. Spend-down Retro-Enrollment/180 filing timeframe	
2. Aetna to post draft documents to website	
3. Pregnancy Application Processing	
4. Verify Aetna Telephone Number	
5. Delays in receiving TPL information due to DHH transition	
6. Bayou Health PCP Referral Policy (Informational Bulletin)	

Call Statistics:

- Number of Callers – 250 plus
- Number of Assignments – 6

Meeting Facilitator:
Mary TC Johnson, Deputy Medicaid Director

DHH Announcements
Communication:

- Meeting summaries will be posted on the makingmedicaidbetter.com (Select I am a….provider from left side menu; then select Provider Teleconference Summary). Last week's summary is available on line today.
- Other sources of communication for providers:
  - *bayouhealth@la.gov*
  - *www.MakingMedicaidBetter.com (good general information and 2 specific items below)*
    - Informational Bulletin 12-27 Providers Issue Escalation and Resolution (recently updated)
    - Health Plan Advisories

Follow-Up Assignments from Previous Call:

- **Provider Directory Point of Contact for each health plan.**
  All five prepaid plans have contracting contact information online at www.makingmedicaidbetter.com (On the left side navigation bar select "I am a health care provider. Then, select "Useful contacts". http://new.dhh.louisiana.gov/index.cfm/page/1065.
- **2015 CPT/HPC code updates**
  DHH received the current file from CMS in November. Plans depend on DHH to update the fee schedules. DHH is in the process of updating this. DHH still needs to complete the review and conduct system changes.
- **Spend-down Retro-Enrollment/180 filing timeframe**
  This is still under DHH Review.

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Questions & Comments

Q: *How will the inclusion of hospice in Bayou Health affect the way providers will bill for regular Medicaid, room/board and nursing homes*?
A: In the past, members could no longer stay in Bayou Health once they entered hospice. Effective Feb. 1 Bayou Health members needing community based hospice services (basic care, continued care, respite and episodic inpatient care) will stay in Bayou Health and receive hospice services through their Bayou Health MCO. Community based hospice providers will have to contract through the MCOs to provide services to this population.
Medicaid populations not enrolled in Bayou Health, including long-term care/nursing home residence, will continue to receive their hospice benefits through Legacy/Medicaid as they do today.

Q: How will it affect dual eligibles?
A: Dual eligibles are not in Bayou Health. If a member has a primary other than Medicare, they could be in Bayou Health. Members with Medicare as primary will stay the same.

DHH has been working with the Hospice Association for several months and they can share additional light on this for their members. DHH will also develop an informational bulletin on hospice.

Q: Is there any way to work with the payers to address the low reimbursement for the pediatricians in the state?
A: Contractually, Medicaid maintains a rate floor which is the current published Medicaid fee rate. Providers are welcome to negotiate with the health plans but it would depend on the market as to what they would pay to a provider. MCOs have more flexibility in rate setting. Also, keep in mind that the rates we pay them are based on the Medicaid rate floor.

Q: How are plans addressing specialty adequacy in remote areas?
A: Network Adequacy is a part of the contract. The MCOs must address it and CMS looks at it as well. We also recognize true gaps. For specialist and subspecialist the requirement is that 75% of the members must be within 60 miles of a specialist and 100% of the members must be within 90 miles of a specialist. We work together collaboratively to try to fill the gaps. MCOs can also sign single case agreements. Ultimately, the MCO still has to meet the need.

Q: Will MCOs and Louisiana Medicaid pay for telemedicine?
A: Telemedicine is payable in Louisiana. The MCOs will have to pay the minimum that DHH pays. They can go beyond that. We do not however pay a host fee, but the MCOs may at their option.

Q: Will mental health providers be able to enroll now that behavior health is moving to the MCOs?
A: Magellan will continue their contract and manage all Medicaid specialized behavioral health services through November 31, 2015, so providers will need to be contracted with Magellan to provide these services. Effective December 1, 2015 DHH will transition behavioral health services into Bayou Health for all Bayou Health Members so they are beginning to reach out to providers to build their networks for Dec. 1. DHH is working with Magellan, MCOs, providers and other stakeholder to develop a specific transition plan and will be sharing additional information as we move towards the transition. In the meantime you can send specific questions directly to bayouhealth@la.gov and check the website as well.

Q: Does DHH have any information (requirements, notices, etc.) on Aetna's plan other than the contact number?
A: Aetna is a brand new plan and has been building their Medicaid network since contract award in October. Aetna is waiting on DHH to release their drafts. The compliance officer will work on getting the drafts posted. If you have questions about contracting with them, you can go to makingmedicaidbetter.com. ***After Call Response:*** *The draft provider handbook is available online at http://www.aetnabetterhealth.com/louisiana*

Q: We received a notice that inpatient services will no longer require PreCert. Is this the same for Bayou Health?
A: No, it is not. PAs will be required. There is an RA message on www.lamedicaid.com dated Jan. 1, 2015 that *references these changes.*

Q: In reference to the above question, is it the same for retroactive Prior Authorizations?
A: Yes. This is correct.

Q: If a pharmacy submits a claim for a recipient who is fee for service and they transfer to Bayou Health will the MCO send any primary insurance information to the pharmacy?
A: Yes. All the Health Plans *are required to return primary insurance information. If a pharmacy bills a claim on a recipient we have the explanation of benefits that will go out to deny it and tells them what primary insurance to bill. It also contains the toll free number for that insurance for the provider to contact them.*

Q: In reference to the above question, what is the rejection code?
A: 507

Q: For members transitioning out of fee for service, will DME be covered?
A: Yes it will be covered through the Bayou Health MCO

Q: How many members will be transitioning from fee for service to Bayou Health?
*A: We had two types of plans previously, CCN-P*repaid *and CCN-S*hared Savings*. Effective Feb. 1 there will no longer be a CCN-S*hared Savings*. This represented 490,000 members. This is the bulk of the population that will be transitioning into a Bayou Health MCO. There are a few other populations that now have the choice to OPT-IN to Bayou Health, include waiver populations and members on the waiting list for certain waivers.*

Q: Do we have to individually enroll in each MCO?
A: Yes. While providers are not required to contract/enroll with any or all MCOs it is required if the provider wants to bill for Medicaid services for those members. All providers must enroll in each MCO individually. Information about contracting is on the www.makingmedicaidbetter.com and the individual health plan websites.

Q: When CHS is dissolved how patients who have PA's through February and beyond be handled? Will the PAs automatically continue?

A: DHH has contractual requirements for the MCO to honor existing PAs for 30 days regardless of the provider's network status. The provider will have to bill the appropriate MCO for payment. The MCO information is available when you check Medicaid eligibility. The MCO then has up to 90 days to conduct their on RA review and provide for necessary services either in-network or through other single case agreements. This policy applies to all member transitions between FFS and Bayou Health, as well as MCO to MCO.

After Call Response: *For services approved beyond 30 days the provider will need to submit a new PA request to the MCO. It is the responsibility of the provider to submit this request as soon as possible in order for the MCOs to review and make their determinations. If the MCO is unable to make a timely determination (approval or denial) they must continue services and durations previously approved until their own determination is made.*

Q: If a provider submits an appeal does the 180 day timely filing still stand?
A: The 180 timely filing requirement by DHH is specific to the original claim submission. We do not specify deadlines for appeal or reconsideration. This is a decision made by each individual health plan. The Health Plans *have internal processes for appeals as well. The providers also have the option of a State Fair Hearing.* **After Call Response:** A providers must go through the internal MCO appeal process before requesting a State Fair Hearing.

Q: Will Molina adopt the 180-day timeframe as well for hospice and room/board?
A: Yes. An RA message was posted on lamedicaid.com on 1/20/15 with the details. There are some exceptions that are listed on the RA message.

Q: What will timely fling be for spend down members?
A: This is still being reviewed by DHH. Mary will follow up. **After Call Response:** It is still based on the date of eligibility determination – before it was 365 days from date of eligibility determination and will now be 180 days from date of eligibility determination.

Q: How will health plans know when retro eligibility is approved?
A: Health plans will receive the retro eligibility date.

Q: Will there be a link on the website to break out the Questions and Answers for behavioral health?
A: Yes, absolutely. We are working on it and expect to have it shortly. If you are not on the Bayou Health subscriber's list, sign up at makingmedicaidbetter.com. On the right hand side of the page, click the "subscribe" button, or go directly to this link: http://new.dhh.louisiana.gov/index.cfm/communication/signup/3. You should sign up because we send out blast communications.

Q: There are 350 private agencies serving behavioral health under Magellan, will there be some coordination of credentialing for those providers?
A: The providers will have to contract with the MCOs directly. We are looking for ways to simplify the process where possible.

Q: Is it necessary to have a PCP referral on file for Medicaid patients, prior to being seen by a specialist?

A: Providers need to check each MCOs policy on referrals. Look on the bayouhealth.com member website and it talks about referrals for specialist. In some instances the provider requests the referral for assurance but that is on their end.

Q: We continue to call the Aetna representative but no one ever picks up. What should we do?
A: The compliance officer will verify the number. Please send an email to bayouhealth@la.gov.
After Call Response: The provider phone number is working as expected. The number is 1-855-242-0802. The compliance officer has reached out to Aetna regarding the issue reported by the provider on the noon call.

Q: Will circumcisions be covered by all Health Plans as an added benefit?
A: Yes, effective Feb. 1. Providers should check with each individual Health Plan as to whether this is for elective circumcisions as well. Medicaid will not cover circumcisions.

Q: How do we know where members can purchase glasses for each Health Plan?
A: Go to the provider directory or contact each Health Plan. This differs from Plan to Plan.

Q: Why have there been delays in approval of OB/GYN applications? Is this due to pregnancy applications no longer being a priority?
A: Send an email to bayouhealth@la.gov and we will have Eligibility look into this. It has to do with the ACA and federal changes with how applications must be processed. This has caused the queues to be extended.

Q: Will a member still be able to choose Legacy Medicaid?
A: The majority of the populations are now mandatory for Bayou Health. There are still some who are voluntary which means we assign them into a MCO but they are informed that they have the opportunity to opt out if they so choose. We also have voluntary opt-in (the waiver population) members that must actively select to be part of Bayou Health. Effective Feb 1. those who are on the NOW waiver registry will also be allowed to opt-in. While all opt-in populations can elect to opt out of Bayou Health at any time and return to FFS Medicaid, they cannot opt back in until the next open enrollment period.

Q: Are all of the fee schedules going to be the same?
A: Each MCO has its own fee schedule. There is a fee schedule/rate floor and this is a minimum reimbursement rate unless a provider wants to negotiate another rate.

Q: After today, members have until April 29, 2015 to change plans, correct?
A: Correct

Q: What day of the previous month do members have to change for it to be effective the next month?
A: The second to last day of the previous month.

Q: Since Aetna has nothing available online at this time, can they verify that the guidelines for referrals are the same for Louisiana as they are for Texas?
A: We will have the compliance officer get Aetna's information posted. It will be priority to get something posted today.

After Call Response: The draft provider handbook is available online at http://www.aetnabetterhealth.com/louisiana

Q: What is the change that is taking place with the new contracts? Will traditional Medicaid no longer exist?
A: Yes, traditional Medicaid will continue to exist after Feb. 1. Last week's provider call summary contains the details that were discussed last week on this topic. Bayou Health has had 2 managed care models, a traditional full risk model like on the commercial side (CCN-p) and the enhanced primary care case management model (CCN-S). The CCN-S model only contracted with the PCP and was paid a lower management fee by DHH. Effective Feb. 1 DHH will no longer have the CCN-S model. We are only operating a full risk model. We do have one completely new plan, Aetna and UnitedHealth who has been a CCN-S and has now contracts as an MCO. Providers will have to re-contract with UHC under their new MCO plan Feb. 1 there will still be 300,000 or so members still in fee for service.

Q: HMS is no longer doing TPL updates for Medicaid. Providers are having trouble getting these updated. How is this being addressed?
A: Each Bayou Health Plan has individually contracted with HMS. The Department is in transition with HMS and the newly awarded contract vendor. We are also looking at what is contractually viable. Please send specifics to bayouhealth@la.gov and I will have DHH or Bayou Health look at this.

Q: When we send questions will you respond directly or post the question?
A: We will do both.

Q: I submitted a contract with Aetna last year and have not received written confirmation of inclusion, how can I get written confirmation from Aetna?
A: Send email to bayouhealth@la.gov and we will send it to Aetna. You can also do a provider search